D COUNTY OF SAN FRANCISCO

BILLING PROCEDURE FOR HOSPITAL SERVICES

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John F. Forbes & Company
CERTIFIED PUBLIC ACCOUNTANTS

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MEMBER OF THE
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WITH OFFICES IN PRINCIPAL CITIES

CROCKER BUILDING
SAN FRANCISCO 94104

CITY AND COUNTY OF SAN FRANCISCO

BILLING PROCEDURE FOR HOSPITAL SERVICES.

San Francisco, California
July 1, 1966

CITY AND COUNTY OF SAN FRANCISCO

BILLING PROCEDURE FOR HOSPITAL SERVICES

GENERAL

These procedures covering billing for individual Medicare patients have been prepared in accordance with Controller's Contract Number 703, dated April 11, 1966.

In implementing the California Medical Assistance Program (Casey Act) and the Federal Medicare Program, Blue Cross of Northern California will act as the fiscal intermediary for Northern California hospital services. California Physicians Service is the intermediary for California medical (doctors') services. So that bills rendered for services provided by these programs by the three City and County of San Francisco hospitals may uniformly comply with the requirements of the two programs, all billing data for hospital inpatients and outpatients will be assembled by the Controller's Central EDP Complex for completion by the hospitals and submission to the intermediary.

The gathering and submission to EDP of the data necessary for billing under these medical aid programs will be governed by the following procedures which become effective as of July 1, 1966. These procedures are being issued to provide an immediate means of implementing the provisions of the Social Security Administration Hospital Manual HIM-10, and will be considered in conjunction therewith.

Because of the limited time available for their preparation, no attempt has been made to integrate these initial billing procedures with related hospital accounting and statistical requirements.

Existing procedures will remain in effect for the present in these areas. These initial billing procedures will produce the data necessary to bill for coverage under both the State and Federal programs. The term Medicare as used hereinafter applies to both the State and Federal programs.

It is anticipated that many changes will be made to these procedures as the Medicare programs are implemented. The recommendation of desirable changes is to be encouraged rather than discouraged. To ensure that changes to this procedure can be properly coordinated and controlled, the channels through which recommendations for change will flow are described on Page 16.

LAGUNA HONDA AND HASSLER HOSPITALS

At present, basic admitting and certification data, ward rate, and length of stay for Medicare patients at these two institutions are gathered on worksheets. At Laguna Honda Hospital cards are keypunched therefrom and sorted into billing order. Cards for Hassler Hospital are keypunched and sorted by the Department of Public Health. The cards are transmitted to Central EDP for bill preparation. Skeleton listings of Medicare patients are also prepared for the next month's billing. Completed billing tabulations and skeleton listings are returned to the Department of Public Health for review, certification, and distribution.

Except for any changes which may be necessary subsequent to Blue Cross audit of bills submitted for coverage under the Casey Act, existent procedures will remain in effect at Laguna Honda and Hassler Hospitals for submitting billing data to the Department of Public Health until further notice.

It will be necessary to prepare a Federal Form SSA-1453 (see Exhibit A) for each patient eligible for Federal coverage and to have these forms signed by the patients or their representatives. A Form SSA-1453 must be prepared for each inpatient for each month to be billed.

Upon receipt of the monthly tabulations of patients' charges from the Department of Public Health, the charges will be transcribed from the tabulations to the individual SSA-1453 forms for Federal billing purposes by the hospitals.

Effective July 1, 1966, Blue Cross has offered to accept hospital insurance billings for patients having both State and Federal coverage on a single Federal Form SSA-1453 for each inpatient, or SSA-1483 for each outpatient (see Exhibit B). Separate billings will be made for patients having State coverage only. The present State billing format will continue to be utilized for the billing of patients having State coverage only.

SAN FRANCISCO GENERAL HOSPITAL

The following procedures for processing Medicare billing for San Francisco General Hospital will govern from July 1, 1966 until further notice.

Methods presently in effect for accomplishing State billings for the months of March through June 1966 will continue until the billing for these four months has been completed.

The policy underlying these procedures is that all necessary basic data will be recorded at San Francisco General Hospital for all patients admitted thereto. These records will be transmitted daily to the Chief Accountant, Department of Public Health, for review.

Subsequent to review, the records will be processed by the Controller's Central EDP Complex, which will produce monthly tabulations of charges by patient with separate tabulations for each type of coverage. These tabulations will be reviewed by the Chief Accountant, Department of Public Health, and further processed as follows:

Federal Coverage. Tabulations for patients having Federal or Federal and State coverage will be transmitted to the Supervisor of Billing, San Francisco General Hospital, for the transcription of charges from the billing tabulations to the Federal billing forms, SSA-1453 for inpatients and SSA-1483 for outpatients, and for completion of the Federal forms and their submission to the intermediary.

State Coverage Only. The Chief Accountant, Department of Public Health, will certify these tabulations and transmit one copy to Blue Cross and one copy to the Supervisor of Billing, San Francisco General Hospital.

No Medicare Coverage. Tabulations of charges for patients without Federal or State coverage will be transmitted to the Supervisor of Billing for the establishment of accounts receivable and appropriate collection effort.

Patients accounts receivable records for Federal and State billings will also be maintained by the Supervisor of Billing.

To provide for adequate coordination of effort, Mr. James Quigley, Chief Accountant, Department of Public Health, is assigned the responsibility for overall coordination of billing activities. The coordination of billing activities within San Francisco General Hospital is assigned to Mr. Kevin McGettigan, Assistant Administrator. The coordination of billing activities within the Controller's Department is assigned to Mr. George Carey, Head Accountant.

DATA REQUIRED - SOURCES AND RESPONSIBILITY

Description	Source	Responsibility
Hospital name		Central EDP
Provider number		"
Vendor code		"
Patient group code	Admitting data	Director of Admissions
County code		Central EDP
Aid code	Admitting data	Director of Admissions
Federal claim number (1)	"	"
State certification number (1)	"	"
Record unit number	As assigned	"
Patient name	Admitting data	"
Birth date	"	"
Date of admission	"	"
Ward assigned	"	"
Date application and declaration submitted to Social Service Department	SFG Social Service	"
Transfers (3):		
Patient name	Ward Census	"
Record unit number	"	"
Transfer date	"	"
Ward from and to	"	"
Discharges and deaths (3):		
Patient name	"	"
Record unit number	"	"
Date	"	"
Ward	"	"
Discharge code	"	"
Total days	Calculated	Central EDP
ICD code (2) (3)	Admitting data	Director of Admissions
Procedure code	"	"
Daily rate (4) (5)	Central EDP	Dept. of Public Health
Gross amount	Calculated	Central EDP
Patient liability (1)	Admitting data	Director of Admissions
Other coverage (1)	"	"
Net amount billed	Calculated	Central EDP
Certification signature		Dept. of Public Health

(1) Patients presenting Federal claim or State certification cards will be accepted for the coverage indicated upon admission. For patients sixty-five years of age or over, lines 1 through 14 of a Federal Form SSA-1453 or lines 1 through 13 of a Federal Form SSA-1483 will be completed for each admission. Upon completion, the billing copies of these forms will be transmitted to the Supervisor of Billing. (See "Application and Declaration" procedures covering admission of patients having neither Federal claim nor State certification cards.)

(2) The ICD code for interim billing purposes will be determined from the initial diagnosis. A medical records employee will be stationed in the admitting office on the day shift to record initial diagnosis and to report changes in ICD code as necessary. This employee will report to the Director of Admissions, with technical supervision to be provided by the Chief of Medical Records.

(3) The Director of Admissions will be responsible for providing a copy of each daily ward census report with discharges coded as appropriate to the Chief Accountant, Department of Public Health.

(4) The Director of Admissions will be responsible that a copy of each outpatient service order or a list of outpatient visits as appropriate is submitted to the Chief Accountant, Department of Public Health, for each day upon which each clinic or outpatient department is operative (see "Outpatient Billing" procedures).

(5) Ward, clinic, and auxiliary department rates will be maintained in a master table by Central EDP (see Appendix). The Chief Accountant, Department of Public Health, will notify Central EDP of any changes in rates.

GATHERING ADMITTING DATA

The Director of Admissions is being provided with personnel adequate to accomplish admitting and certification processing for both inpatients and outpatients on a current basis, twenty-four hours each day and seven days each week.

A list of each day's admissions will be submitted to the Chief Accountant, Department of Public Health, within forty-eight hours after the date of admission by the Director of Admissions, except that Friday lists may be submitted on the following Monday, and Saturday and Sunday lists may be submitted on the following Tuesday. The Admission Report Form (see Exhibit C) will be used for this purpose, with the following data entered for each inpatient or outpatient admitted:

County code
Aid code
Record unit number
Name
Birth date
ICD code
Procedure code
Ward number
*Federal claim number
*State certification number
*Patient liability
*Other coverage
*Patient group code

*These items will be included if available at time of admission. Otherwise, such data will be submitted as changes of status (see "Changes of Status" procedures).

The patient group code will indicate patients' coverage and type of service provided so that billing tabulations can be properly segregated. The following codes will be used:

	........Codes........	
Coverage	Inpatient	Outpatient
Federal A	11	21
Federal A and B	12	22
Federal A with State	14	24
Federal A and B with State	15	25
State I only	17	27
State II only	18	28
No Medicare coverage	19	29

The admission date will be entered at the top of the admission report. A separate sheet will be used for reporting each day's admissions. All patients admitted not including newborn will be listed on the admission report form regardless of coverage.

FEDERAL HEALTH INSURANCE CLAIM NUMBERS

When a patient over sixty-five who does not have a Federal health insurance card is admitted, the Social Security Administration district office will be immediately requested by letter to furnish a health insurance card or claim number. A copy of each letter of request will be transmitted to the Chief Accountant, Department of Public Health. The date of the letter of request will be entered on the admission report.

When the claim number has been determined, the claim number will be reported as a change in status (see "Changes in Status" procedures). If it is determined that the patient has no Federal coverage, the date of such denial will likewise be reported.

Therefore, the daily admission report will indicate either the Federal claim number, the date of request for claim number, or the date of denial of such request for each person admitted of age sixty-five or over.

STATE APPLICATION AND DECLARATION FORMS

The policy has been established that the State of California application for aid and declaration of eligibility forms will be completed prior to admission for each person requesting admission to the Hospital who does not present a State certification card or whose claim to have a card or pending application cannot immediately be verified.

Verification of a patient's claim to be certified will be indicated by entering the patient's certification number on the admission report. The date of submission of the application will be entered on the admission report in verified cases of pending applications. Therefore, the admission report will indicate for each such person admitted either a certification number, an application date, or a denial date.

Completed applications and declarations will be forwarded to the Department of Social Services daily. A transmittal letter will be prepared for each day's application and declaration forms showing the transmittal date and the patients' names and record unit numbers. A copy of the transmittal letter will be forwarded to the Chief Accountant, Department of Public Health each day. On days when no application and declaration forms are completed, a letter will be prepared for the Chief Accountant, Department of Public Health, indicating that no applications or declarations were completed on that date.

For patients for whom applications are made, the certification numbers assigned or dates of denial, and the resultant patient group codes will be reported as changes in status (see "Changes in Status" procedures).

OUTPATIENT IDENTIFICATION AND VISITS

An identification card (see Exhibit D, Follow-up Clinic Card) will be prepared by the Admitting Department and issued to each outpatient admitted on the day of admission.

In emergency cases where the patient does not have an identification card, it will be the responsibility of the department providing service to the patient that the patient is not released without clearing through the Admitting Department.

Nonemergency patients not having valid identification cards who request outpatient services at the clinics or departments will be directed to the Admitting Department by the outpatient clinic or department before any service is performed.

The outpatient department and clinic staffs will be directed that no outpatient services will be rendered to a patient who does not present a valid identification card (see Exhibit D) except for emergency cases.

CHANGES IN STATUS

The Director of Admissions will report all changes of patients' status to the Chief Accountant, Department of Public Health. The admission report form will be used for this purpose, with the words "Changes in Status" entered below the date space on the form. A change of status report will be completed for each day even if there are no changes to report. Such reports will indicate "No changes to report" in the body of the form.

The following data must be included for each patient on all change of status entries:

Record unit number
Patient name
Birth date

The following items may be entered or changed by entering the correct number or amount in the appropriate column of the admission report form:

Aid code
Patient group code
ICD code (for discharges or deaths only)
Procedure code
Date application for coverage denied
Federal claim number
State certification number
Patient liability
Other coverage

TRANSFERS, DISCHARGES, BIRTHS, AND DEATHS

Transfers, discharges, births, and deaths will be reported by means of the daily ward census reports. This will require a third copy of the daily census report to be made for each ward. The third copy for all changes occurring up to midnight of the previous night will be headed "Medicare Copy" and will be routed directly to the Director of Admissions each morning. The Director of Admissions will ensure that:

1. A copy of the census report is received from each ward each day.
2. Patients' names and unit record numbers are correct.
3. Wards from and to correspond for each transfer.
4. In the case of transfers to other City and County institutions, such institutions are advised as to the patients' Medicare coverage and claim or certification numbers.
5. The appropriate CMAP discharge code is entered on the census report in the "Discharged" column for each discharge or death.
6. The ICD code changes are reported on the census report or as changes in status where applicable upon discharge.
7. The complete set of ward census reports for each day are transmitted to the Department of Public Health by 5 P.M. of the day following the census report date.

OUTPATIENT VISIT AND TREATMENT REPORTS

All services rendered to outpatients must be recorded and priced for Medicare purposes. Insofar as possible, this will be accomplished through the submission of an extra copy of the document requisitioning or ordering the service. Otherwise the clinics and departments will prepare a list of visits, treatments, tests, etc.,

using CMAP Form CL-88 for this purpose (see Exhibit E). The clinic or department name and the date of service will be entered in the upper right hand corner of the Form CL-88 above the Facility No. space. The following clinics and departments are affected:

Clinics	Departments
Chest	Anesthesia
Dental	Cardio-Pulmonary
Ear-nose-throat	EEG
Emergency	EKG
Eye	Laboratory
Follow-up	Pathology
Pediatric	Pharmacy
Psychiatric aid	Physical therapy
Psychiatric outpatient	Radiology
Pre-natal	Surgery
	Chest
	Ortho

Where a copy of the document requisitioning or ordering a service cannot be made available, the clinics will use one line of the Form CMAP CL-88 to record each outpatient visit, indicating the record unit (B) number (in the Case Number column), the name, and the birth date for each patient treated, in the appropriate columns of the form.

The departments except pharmacy will also indicate the record unit (B) number in the Case Number column, and the patient's name and birth date for each outpatient treated, and will use the remainder of the line to describe the type of service performed.

The outpatient visit and treatment documents or reports will be transmitted to the Director of Admissions on the day following the date of service.

Where outpatient treatment requires pharmacy issue, the clinic or department will prepare a pharmacy requisition (see Exhibit F) with the word "outpatient" and the patient's record unit number entered above the patient's name on the requisition. A copy of each outpatient requisition will be made and priced by the pharmacy. These priced copies will be transmitted to the Director of Admissions.

The Director of Admissions will be responsible that all outpatient visit or treatment and pharmacy issue documents are priced by the departments providing the services and for their prompt submission to the Department of Public Health.

The clinics and departments, the proposed reporting documents, and the initial prices to be used are shown in the Appendix, Page 19.

CORRECTIONS OF PATIENT IDENTIFICATION DATA

The patient's name, record unit number, and birth date are the key data used by the Central EDP billing program for identifying patients and gathering billing data for each patient.

Any correction to patient's name, record unit number, or date of birth will be submitted to the Chief Accountant, Department of Public Health, by the Director of Admissions in letter form. For each correction, the correction request will indicate the patient's name, record unit number, and birth date as previously reported, followed by the correct data.

BILLING PROCEDURE

The following paragraphs will govern the processing of billing data for patients at San Francisco General Hospital.

The Chief Accountant, Department of Public Health, will ensure that:

1. An admission report, a change of status report, a complete set of ward census reports, and the outpatient treatment documents or reports are received from the Hospital each day as scheduled. On days where no changes in status occur, the Hospital will prepare an admission report form headed "Changes in Status," dated, and indicating "no changes to report" in the body of the report.
2. All documents relating to patient billing received from the Hospital are promptly reviewed and transmitted to Central EDP for processing.
3. A copy of all billing tabulations is provided for the Billing Supervisor at San Francisco General Hospital.
4. All completed billings are properly certified and transmitted to the intermediary.

CENTRAL EDP PROCEDURES

Controls will be maintained by Central EDP for all billing documents received from the San Francisco General Hospital. From these controls, it will be determined that an admitting report, a change in status report, and the ward census reports for each day of the month have been received before a month's billing is closed out. The controls will also reflect that outpatient documents or reports have been received from each outpatient clinic or department for applicable days according to the department or clinic schedule. Any necessary follow-up will be handled through the Chief Accountant, Department of Public Health.

All keypunching and verification of billing documents will be accomplished by Central EDP currently on a daily basis. Central EDP will be responsible for the accurate reflection within the system of all data as reported by San Francisco General Hospital on the billing documents.

From data submitted by Hassler, Laguna Honda, and San Francisco General hospitals, Central EDP will complete the billing tabulations essentially in the form presently in use for Laguna Honda and Hassler hospitals.

A card will be punched for each admission, change in status, outpatient visit, and correction submitted by San Francisco General Hospital.

The EDP system will compute the following data for each patient:

1. Dates of inpatient service, total days' stay in each ward, and resultant gross amounts chargeable.
2. Dates of outpatient services, department or clinic, and charges.
3. Total charges for each patient.
4. Control totals.

The billing tabulations will be run in separate groups as governed by the patient group code.

Three copies of the billing tabulations will be transmitted to the Chief Accountant, Department of Public Health, for review and distribution.

PROPOSING CHANGES TO BILLING PROCEDURE

These billing procedures are intended to provide an interim basis for gathering data necessary to accomplish billings for hospital services under known Federal and State requirements as of June 30, 1966.

It is anticipated that continual changes in this procedure will be made as the State and Federal programs become more clearly defined as the result of implementation of the Medicare programs.

All inquiries regarding application of these procedures will be directed to the Chief Accountant, Department of Public Health. Proposals for changes to the procedures regardless of their source will also be so directed.

It will be the responsibility of the Chief Accountant, Department of Public Health, to evaluate all proposals for change in these procedures with the appropriate representatives of the City and County departments or other agencies involved.

So that these procedures may be updated as required and effectively enforced, the following requirements will be met to affect a change in these procedures:

1. Recommendation of the proposed change by the Chief Accountant, Department of Public Health.
2. Approval by the Assistant Director of Public Health for Hospital Services.
3. Approval by the Director of Public Health.
4. Approval by the Chief Administrative Officer.
5. Approval by the Controller.

All recommendations for changes originating at San Francisco General Hospital will be reviewed by the Assistant Administrator, Mr. McGettigan. Conferences on specific interdepartmental problems can be arranged through Mr. Quigley, Chief Accountant, Department of Public Health.

MEDICARE BILLING RATES

The interim rates for Medicare billing listed in the appendix hereto are based on costs determined by the San Francisco General Hospital accounting department. The Department of Public Health has obtained permission from the Social Security Administration to

continue to bill for inpatients at all inclusive ward rates until July 1, 1967. Therefore, no data other than that reported on the admission report, ward census report, report of changes in status, outpatient visit or treatment documents, and corrections will be required to enable Central EDP to prepare the billing tabulations for inpatients.

The pricing of outpatient charges will be accomplished in the clinics and auxiliary departments rather than by the accounting or other central department. No change in this policy will be permitted without specific approval by the Department of Public Health.

APPENDIX

MEDICARE BILLING RATES EFFECTIVE JULY 1, 1966

Cost Center	Basis	Rate
HASSLER HOSPITAL	Ward day	$15.31
LAGUNA HONDA HOSPITAL:		
Hospital	Ward day	13.67
Modified hospital	"	8.64
Rehabilitation	"	23.57

SAN FRANCISCO GENERAL INPATIENT RATES

Ward No.	Service	Basis	Rate
1	Admitting and emergency	Ward day	$25.00
11	Intensive care	"	76.25
12	Neurosurgery	"	76.25
13	Surgical and orthopedic - Female	"	41.14
14	Surgical - Male	"	47.59
15	EENT	"	35.80
18	Clinical studies	"	*
22	Orthopedic - Male	"	33.83
23	Surgical - Male	"	47.59
25	Urology	"	41.84
32	Orthopedic - Female	"	41.14
34	Medical - Female	"	40.92
35	Medical - Female	"	40.92
41	Medical - Male	"	40.92
42	Medical - Male	"	40.92
43	Medical - Male	"	40.92
44	Medical - Male	"	40.92
45	Municipal	"	*
52	Tuberculosis - Male	"	31.56
53	Tuberculosis - Female	"	31.56
54	Tuberculosis - Female	"	31.56

*Rates to be determined.

Ward No.	Service	Basis	Rate
61	Isolation	Ward day	$61.99
62	Overflow - T.B.	"	31.56
64	Psychiatric - Female	"	45.18
72	Tuberculosis - Male	"	31.56
73	Tuberculosis - Male	"	31.56
74	Tuberculosis - ICU	"	*
75	Tuberculosis - Pediatrics	"	51.06
82	Pediatrics	"	51.06
83	Pediatrics	"	51.06
84	Obstetrics	"	44.78
85	Nursery	"	19.57
96	Gynecology	"	59.96
92	Psychiatric - Female	"	36.29
93	Psychiatric - Male	"	36.29
94	Psychiatric - Male	"	36.29
95	Psychiatric - Male	"	45.18

*Rates to be determined.

SAN FRANCISCO GENERAL OUTPATIENT RATES

Clinics	Billing Document	Basis	Rate
Chest	CMAP CL-88	Visit	*
Dental	"	"	$ 6.34
Ear-nose-throat	"	"	*
Emergency	"	"	7.05
Eye	"	"	*
Follow-up	"	"	8.24
Nalline	"	"	2.35
Pediatric	"	"	5.25
Pre-natal	"	"	5.72
Psychiatric aid and outpatient	"	"	11.02
Departments			
Anesthesiology	Anesthesia record	Hour	6.60
Blood bank	F88 Transfusion request	Pint	25.00
Cardio-pulmonary	CMAP CL-88	Test	*
EEG	EEG request	Reading	16.62
EKG	F705 EKG record	Reading	14.06
Kidney machine unit	Usage notice	Hour	19.77
Laboratories	Service orders (various)	Procedure	U. C. fee
Pathology	Service orders (various)	Procedure	U. C. fee
Pharmacy	F710 Prescription	Item	Item cost
Physical therapy	F896 Request	Treatment	7.58
Radiology	F737 Request	Examination	3.54
Special nurse	Request	Shift	Prevailing
Surgical service	F703 Operation record	Hour	35.64

*Rates to be determined.

All requests for additions to or changes in rates will be cleared through the Chief Accountant, San Francisco General Hospital prior to submission to the Chief Accountant, Department of Public Health.

EXHIBIT A

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
SOCIAL SECURITY ADMINISTRATION

INPATIENT HOSPITAL ADMISSION AND BILLING
HOSPITAL INSURANCE BENEFITS—SOCIAL SECURITY ACT

Form Approved.
Budget Bureau
No. 72-R734

1. PATIENT'S LAST NAME | FIRST NAME | MI | 2. HEALTH INSURANCE CLAIM NUMBER

3. PATIENT'S ADDRESS *(Street number, City, State, Zip Code)* | 4. DATE OF BIRTH | 5. SEX ☐ M ☐ F

6. HOSPITAL NAME AND ADDRESS | 7. PROVIDER NO. | 8. MEDICAL RECORD NO. | 9. NAME AND ADDRESS OF ATTENDING PHYSICIAN

10. DATE OF THIS ADMISSION | 11. NAME AND ADDRESS OF ANY INSTITUTION FROM WHICH DISCHARGED DURING LAST 60 DAYS *(If this hospital, give dates of stay)*

12. PAYMENT SOURCE FOR CHARGES TO PATIENT
☐ SELF OR FAMILY ☐ BLUE CROSS BLUE SHIELD ☐ PUBLIC AGENCY *(Give name)*
☐ PRIVATE INSURANCE ☐ EMPLOYER OR UNION ☐ OTHER *(Explain)*

13. PATIENT'S CERTIFICATION: AUTHORIZATION TO RELEASE INFORMATION AND PAYMENT REQUEST. I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize release of all records required to act on this request. I request that payment of authorized benefits be made on my behalf.

SIGNATURE *(Patient or authorized representative) (Signature by mark must be witnessed)* | DATE

14. ADMITTING DIAGNOSIS | EMPLOYMENT RELATED ☐ YES ☐ NO | *If yes, give name and address of employer*

15. DISCHARGE DIAGNOSES OR CURRENT DIAGNOSES *(Primary illness and secondary or complicating illnesses)* | Do not use this space

16. SURGICAL PROCEDURES *(Related to primary illness and other—Show date of each)*

17. STATEMENT OF SERVICES RENDERED ACCOMMODATION	DAYS	RATE	TOTAL CHARGES	NON-COVERED CHARGES
A. 1-Bed			$	$
B. 2-3-4 Bed				
C. 5 or more Beds				
D. Intensive Care				
E. Self Care				
F. WHOLE BLOOD	PINTS FURNISHED	NOT REPLACED	CHARGE PER PINT	
G. Operating Room				
H. Pharmacy				
I. Laboratory				
J. Radiology				
K. Medical, Surgical and Central Supplies				
L. Anesthesia				
M. Inhalation Therapy				
N. Other *(Describe)*				
O. TOTALS			$	$
P. Inpatient Deductible				
Q. Blood deductible	Pts. @			
R. Coinsurance				
S. TOTAL DEDUCTIONS				

I certify that the required physician's certification and recertifications are on file.

18. STATEMENT COVERS PERIOD FROM | TO | 19. TOTAL DAYS

20. DATE GUARANTEE OF PMT. OR UR NOTICE RECEIVED | 21. DATE BENEFITS EXHAUSTED

22. ☐ DISCHARGED ☐ DIED ☐ STILL PATIENT | 23. DATE DISCHARGED OR DIED

24. COMPUTATION OF INTERIM PAYMENT

Reimbursement Amount $

FOR INTERMEDIARY USE

25. VERIFIED PRIOR STAY DATES ☐ NONE | FROM | TO | PROVIDER NO.

26. SIGNATURE OF HOSPITAL REPRESENTATIVE | DATE FORWARDED | 27. APPROVED BY | DATE

FORM SSA-1453 (4-66)

EXHIBIT B

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
SOCIAL SECURITY ADMINISTRATION

OUTPATIENT HOSPITAL BILLING

HOSPITAL AND MEDICAL INSURANCE BENEFITS – SOCIAL SECURITY ACT

Form Approved.
Budget Bureau No. 72-R738

1. PATIENT'S LAST NAME	FIRST NAME	MI	2. HEALTH INSURANCE CLAIM NUMBER
3. PATIENT'S ADDRESS *(Street number, City, State, Zip Code)*			4. DATE OF BIRTH ___ | ___ | ___
			5. SEX ☐ M ☐ F
6. HOSPITAL NAME AND ADDRESS	7. PROVIDER NO.		9. NAME AND ADDRESS OF PHYSICIAN REQUESTING OUTPATIENT SERVICES
	8. MEDICAL RECORD NO.		

10. PAYMENT SOURCE FOR CHARGES TO PATIENT

☐ SELF OR FAMILY ☐ BLUE CROSS BLUE SHIELD ☐ PUBLIC AGENCY *(Give name)*

☐ PRIVATE INSURANCE ☐ EMPLOYER OR UNION ☐ OTHER *(Explain)*

11. DATE OF FIRST VISIT ___ | ___ | ___

12. PATIENT'S CERTIFICATION: AUTHORIZATION TO RELEASE INFORMATION AND PAYMENT REQUEST. I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize release of all records required to act on this request. I request that payment of authorized benefits be made on my behalf.

SIGNATURE *(Patient or authorized representative) (Signature by mark must be witnessed)* | DATE

13. DIAGNOSES *(Primary illness and secondary or complicating illnesses)* EMPLOYMENT RELATED ☐ YES ☐ NO *If yes, give name and address of employer.* | Leave Blank

14. DATE OF EACH SERVICE	FULLY DESCRIBE SURGICAL OR MEDICAL PROCEDURES AND OTHER SERVICES OR SUPPLIES FURNISHED FOR EACH DATE GIVEN	TOTAL CHARGES	HOSPITAL PLAN CHARGES	MEDICAL PLAN CHARGES	NON-COVERED CHARGES
15A. Total Occasions of Service HOSPITAL PLAN | MEDICAL PLAN	15B. Total Charges	$	$	$	$

16. Professional component included in 15B total charges			FOR INTERMEDIARY USE
17. 15B total charges less professional component shown in 16			VERIFIED PATIENT LIABILITY
18. PATIENT PAID A. Deductible			
B. Coinsurance			

FOR INTERMEDIARY USE | PAYMENT DISTRIBUTION

	A. REIMB. RATE	B. A TIMES 15	C. DEDUCTIBLE	D. B LESS C	E. 80% OF D	HOSPITAL	PATIENT
19. PART A							
20. PART B							
21. PART A DEDUCTIBLE AS PART B EXPENSE		A. DEDUCTIBLE AMOUNT	B. REMAINING PART B DEDUCTIBLE	C. A LESS B	D. 80% OF C		
					TOTALS	$	$

I certify that the required physician's certification on file.

22. SIGNATURE OF HOSPITAL REPRESENTATIVE	DATE FORWARDED ___ | ___ | ___	23. APPROVED BY	DATE ___ | ___ | ___

FORM SSA-1483 (6-66)

EXHIBIT C

HOSPITAL____________________ DATE__________________ Page_____ of_____

PROVIDER NO.____________________

VENDOR CODE____________________

PATIENT GROUP	COUNTY CODE	AID CODE	HOSPITA (RECORD U NUMBER	EDERAL NO. OR DATE REQUESTED	STATE NO. OR DATE REQUESTED	DATE APPLICATION .....DENIED.....	
						FEDERAL	STATE

EXHIBIT C

ADMISSION REPORT

HOSPITAL______________________________

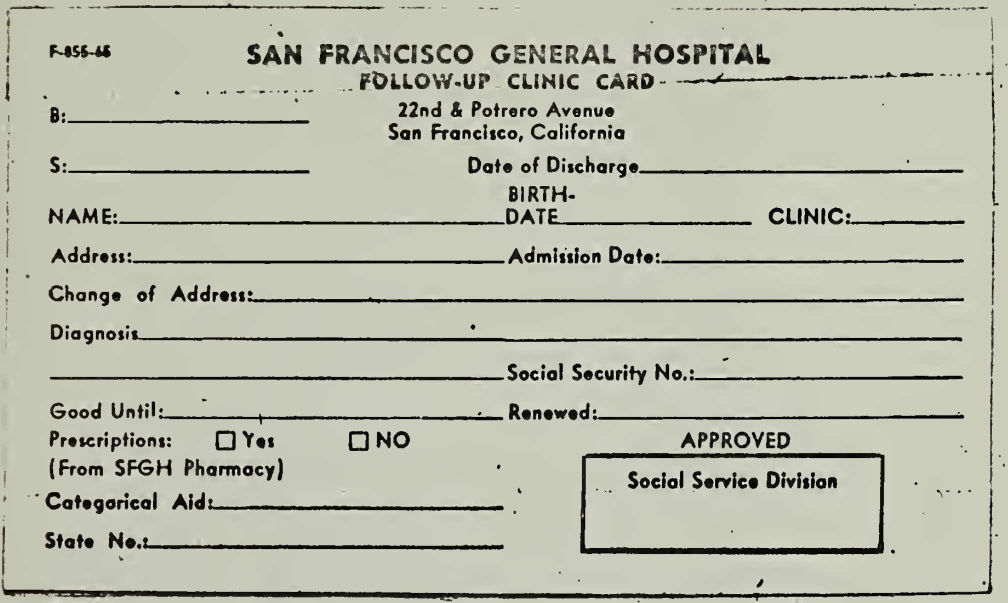
PROVIDER NO.___________________________

VENDOR CODE____________________________

DATE__________________ Page_____ of_____

PATIENT GROUP	COUNTY CODE	AID CODE	HOSPITAL (RECORD UNIT) NUMBER	PATIENT NAME	BIRTH DATE	DATE OF ADMISSION OR SERVICE	WARD ASSIGNED OR TRF. TO	ICD CODE	PROC. CODE	PATIENT LIABILITY	OTHER COVERAGE	FEDERAL NO. OR DATE REQUESTED	STATE NO. OR DATE REQUESTED	DATE APPLICATION .....DENIED.....	
														FEDERAL	STATE

EXHIBIT D



F-856-66

SAN FRANCISCO GENERAL HOSPITAL

FOLLOW-UP CLINIC CARD

22nd & Potrero Avenue
San Francisco, California

B: ____________________

S: ____________________

Date of Discharge ____________________

NAME: ____________________ BIRTH-DATE ____________________ CLINIC: __________

Address: ____________________ Admission Date: ____________________

Change of Address: ____________________

Diagnosis ____________________

____________________ Social Security No.: ____________________

Good Until: ____________________ Renewed: ____________________

Prescriptions: ☐ Yes ☐ NO
(From SFGH Pharmacy)

Categorical Aid: ____________________

State No.: ____________________

APPROVED

Social Service Division

EXHIBIT E

HOSPITAL ____________________ AM PAGE ______ OF ______

ADDRESS ____________________

CITY ____________________ FACILITY NO. ____________

☐ OUTPATIENT GROUP I ☐

☐ INPATIENT GROUP I ☐ VENDOR CODE ____________

COUNTY CODE	AID CODE	CASE NUMBER	LAST	S NT	PATIENT LIABILITY	OTHER COVERAGE	NET AMOUNT BILLED	REASON FOR DISCHARGE

I hereby certify that the service as
and unpaid and represents the enti
certified by their County Welfare De

Use Discharge Codes

1. Transferred - County Hospital
2. Transferred - Non-County Hospital
3. Transferred - Nursing Home
4. Death
5. Discharged to Home
6. Not Discharged

CL - 88 (3-66)

EXHIBIT E

PAGE ______ OF ______

HOSPITAL ______________________________

ADDRESS ______________________________

CITY ______________________________

CALIFORNIA MEDICAL ASSISTANCE PROGRAM

BILLING FORM

SEND TO: BLUE CROSS OF NORTHERN CALIFORNIA
P.O. BOX 1080
OAKLAND, CALIFORNIA 94604

FACILITY NO. __________

VENDOR CODE __________

☐ OUTPATIENT GROUP I ☐ OUTPATIENT GROUP II
☐ INPATIENT GROUP I ☐ INPATIENT GROUP II

COUNTY CODE	AID CODE	CASE NUMBER	NAME	BIRTH DATE		DATES OF SERVICE				TOTAL DAYS	ICD CODE	PROC CODE	DAILY RATE	GROSS AMOUNT	PATIENT LIABILITY	OTHER COVERAGE	NET AMOUNT BILLED	REASON FOR DISCHARGE
			LAST INITIAL	MO	YR	MO	YR	FM	TO									

I hereby certify that the service as described was rendered to the patient named and that the bill is due and unpaid and represents the entire charge for services to this patient. All the above patients have been certified by their County Welfare Department as eligible under the California Medical Assistance Program.

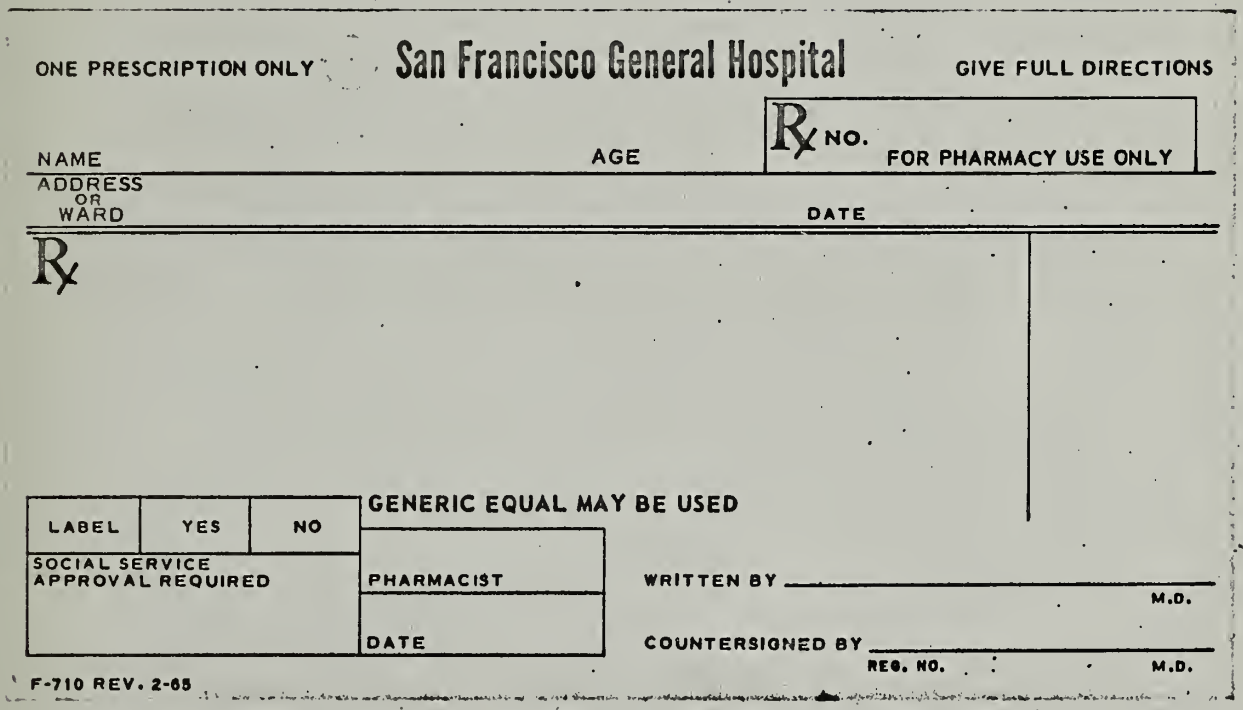
Use Discharge Codes

1. Transferred - County Hospital
2. Transferred - Non-County Hospital
3. Transferred - Nursing Home
4. Death
5. Discharged to Home
6. Not Discharged

____
SIGNATURE & TITLE

CL 88 (3-66)

EXHIBIT F



ONE PRESCRIPTION ONLY

San Francisco General Hospital

GIVE FULL DIRECTIONS

NAME

AGE

℞ NO. FOR PHARMACY USE ONLY

ADDRESS OR WARD

DATE

℞

LABEL	YES	NO

SOCIAL SERVICE APPROVAL REQUIRED

GENERIC EQUAL MAY BE USED

PHARMACIST

DATE

WRITTEN BY ____________ M.D.

COUNTERSIGNED BY ____________ REG. NO. M.D.

F-710 REV. 2-65